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IN THE SUPERIOR COURT OF THE STATE OF CALIFORNIA
IN AND FOR THE COUNTY OF SAN FRANCISCO
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PATRICIA HENLEY,)
Plaintiff,)
vs.) No. 995172
PHILIP MORRIS INCORPORATED; et al.,)
Defendants.)
_____)

DEPOSITION OF WILLIAM H. WARREN, M.D.
December 12th, 1998

REPORTED BY:
NANCY L. BARKER, CSR #10859, RPR

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DEPOSITION OF WILLIAM H. WARREN, M.D.

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BE IT REMEMBERED that, pursuant to Notice of Taking Deposition, and on Saturday, December 12th, 1998, commencing at the hour of 11:12 a.m., at the Law Offices of SHOOK, HARDY & BACON, LLP, One Market Street, Steuart Street Tower, 9th Floor, San Francisco, California 94105, before me, NANCY L. BARKER, duly authorized to administer oaths pursuant to Section 2093(b) of the California Code of Civil Procedure, personally appeared

WILLIAM H. WARREN, M.D.

called as a witness by the Plaintiff, and the said witness, being by me first duly sworn, was thereupon examined and testified as hereinafter set forth.

WARTNICK, CHABER, HAROWITZ, SMITH & TIGERMAN, 101 California Street, Suite 2200, San Francisco, California 94111-5802, represented by MADELYN J. CHABER, ESQ., appeared as counsel on behalf of the Plaintiff.

SHOOK, HARDY & BACON, LLP, One Market Street, Steuart Street Tower, 9th Floor, San Francisco, California 94105, represented by GERALD

V. BARRON, ESQ., and WILLIAM S. OHLEMEYER, ESQ., (appeared video conference) appeared as counsel on behalf of the Defendants.

ALSO PRESENT: Thomas A. Duncan.

VICTOR E. GOULD, M.D.,

having been first duly sworn, testified as follows:

EXAMINATION BY MS. CHABER

MS. CHABER: Q. Could you state your full name for the record and your business address, please?

A. William Howard Warren, my business address is Suite 218, 1725 West Harrison Street, Chicago, Illinois 60612.

Q. I'm handing you a check for $1,000. You charge $500 an hour for your deposition testimony; is that correct?

A. That's correct.

Q. And is that the same amount that you charge for consultation time?

A. Yes, it is.

Q. And how many times have you been deposed?

A. About 10 or 12 times.

MS. CHABER: I've been provided with a curriculum vitae. I still can't pronounce it right. I'd like to attach that as plaintiff's first and something assessing a letter and an attachment dated March -- November 23rd, 1998 which appears to attach the time spent on the Henley case.

(Whereupon, Plaintiff's Exhibit No. 1 was marked for identification.)

MS. CHABER: Q. Dr. Warren, is this current and up to date or is this prior to -- what time period does this cover?

A. Everything up to November the 23rd.

Q. And how much time have you assessed to this case since November the 23rd?

A. Up to this point?

Q. Yes.

A. As of right now?

Q. Yes.

A. I haven't tallied the hours but I spent about two hours in Chicago last week and I spent much of yesterday.

MR. BARRON: Can you hold for just one second?

(Off the record 11:14 a.m. to 11:15 a.m.)

MR. BARRON: I'm trying to get those records together.

MS. CHABER: Q. You said much of yesterday.

A. Much of yesterday, the flight out spending time with the lawyers here and some time this morning.

Q. And the time that you spent this morning was that also with the lawyers?

A. Some of it was, yes.

Q. How much time did you spend yesterday with the lawyers?

A. We started about 1:00 o'clock yesterday and we finished in the office here around 5:30 and

there was some additional discussion in the evening.
Q. And how much time did you spend today with the lawyers?
A. With the lawyers I spent -- what time is it now?
Q. It looks like close to 11:15.
A. Probably two hours this morning, maybe three.
Q. What was your first contact in this case, anything about Ms. Henley's case?
A. I met with Mr. Sirridge in Chicago I believe it was in October of this year.
Q. And Mr. Sirridge is an attorney representing Philip Morris?
A. He is an attorney here at Shook, Hardy & Bacon but I don't know whether it's Philip Morris involved in this case or not.
Q. And you do know that it is a cigarette manufacturer?

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A. Yes.
Q. You don't know which one?
A. I don't know which one.
Q. And what was the nature of this meeting with Mr. Sirridge in October?
A. He asked me to review some records and I believe some x-rays at that time.
Q. Was there anyone else present besides you and Mr. Sirridge?
A. Dr. Victor Gould.
Q. Anyone else?
A. I don't recall if Mr. Duncan was at that meeting or not. I think he probably was not.
Q. Who is Mr. Duncan?
A. He is the gentleman to my left down two.
Q. Another attorney with Shook, Hardy?
A. Yes.
Q. Before that meeting had you read any records or materials regarding Ms. Henley?
A. No.
Q. How long was that meeting?
A. I don't recall. It was probably on the order of two hours.
Q. You reviewed x-rays during those two hours?

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A. Yes.
Q. How many x-rays did you review?
A. Quite a few. I didn't count them.
Q. Which facilities were the x-rays from?
A. I don't recall. There were several facilities that had performed x-rays on this patient but I didn't pay attention as to which facility and which day and which x-ray.
Q. Did you write any notes with respect to your review of the x-rays?
A. No.
Q. Is that your normal practice when you review x-rays at the hospital that you do not make any notes of what your review is?
A. For the purpose of legal counsel or for in my clinical practice?
Q. In your clinical practice let's start

with that.
A. In my clinical practice if I am to see the patient, I make comments about the x-rays at that time.
Q. When you say you make comments, what's the form that those comments take?
A. In my office record I have an office record for that patient.

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Q. And when you do medical-legal, you do not make any notes; is that correct?
A. That's correct.
Q. And have you provided consultation in medical-legal matters to anyone other than a cigarette manufacturer?
A. I have been an expert witness in cases that don't involve a cigarette manufacturer, yes.
Q. How many times?
A. On the order of 10 to 12 times.
Q. Have you ever been deposed in a case as an expert witness involving a cigarette manufacturer before today?
A. No.
Q. And during this first meeting where records were reviewed and x-rays were reviewed and you did not take any notes, did Dr. Gould take any notes?
A. I don't believe so.
Q. Did any of the lawyers take any notes?
A. I don't believe so.
(Mr. Sirridge entered then exited proceedings)
MS. CHABER: Q. Did you subsequently dictate or in any way memorialize the impressions or opinions that you had after this first meeting?

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A. No.
Q. What information were you given before you had this meeting with Mr. Sirridge, Dr. Gould and possibly Mr. Duncan?
A. None. Only that there was a case that Dr. Gould had been contacted first and suggested that I be present as well. I knew nothing about the case beyond that.
Q. And at the time that you began reviewing the records in this case what did you understand you to be reviewing these records for?
A. An interpretation of the clinical presentation in the course of this patient.
Q. And in the course of your review of these records, isn't it true that the clinical physicians that were caring for Ms. Henley believe that she had a primary carcinoma of the lung?
A. That's what the records led me to believe.
Q. And at the end of that meeting did you form your opinion as to what disease or diseases Ms. Henley was suffering from?
A. Yes, I had a preliminary conclusion.
Q. And what was that preliminary conclusion?
A. That she had a mass in the chest that was

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biopsied and proved to be small cell carcinoma.
Q. And at that time did you have any

opinions as to the primary site of that tumor?
A. I had a suspicion that this was not a primary in the lung but rather in the thymus gland.
Q. And what was that based on?
A. That was based on the presenting complaints, the location of the tumor, and the appearance.
Q. How many primary thymic tumors have you diagnosed?
A. Probably 100.
Q. How many of these 100 primary thymic tumors were malignant?
A. Probably 25.
Q. And how many of these primary thymic tumors that were malignant that you diagnosed were diagnosed while the person was still alive?
A. All of them that I recall.
Q. And how many of the 25 malignant primary thymic tumors did the individual have some underlying predisposing factor?
A. I don't understand your question.
Q. There are certain diseases or conditions that are considered to be underlying or predisposing

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conditions for a thymic tumor, correct?
A. There is a correlation with myasthenia gravis.
Q. How about Hashimoto's disease?
A. I'm not familiar with that.
Q. What time period are we talking about where you have diagnosed 25 malignant thymic carcinomas?
A. In my career and that would include my training in thoracic surgery so I would say 10, 15 years.
Q. And how many of the 25 malignant primary thymic carcinomas that you have diagnosed were small cell?
A. None.
Q. And how many of the 25 primary malignant carcinomas that you have diagnosed occurred in the anterior mediastinum?
A. Most of them had some involvement of the anterior mediastinum.
Q. How many of the 25 malignant thymic carcinomas had primary involvement of the anterior mediastinum rather than a spreading or extension into the anterior mediastinum?
A. I don't recall the number.

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Q. And of the cell types of these 25 malignant thymic carcinomas that you have diagnosed over your career, was there a primary cell type?
A. They by and large were simply called malignant thymoma.
Q. And that's thymoma, t-h-y-m-o-m-a?
A. Correct.
Q. Have you ever published any paper or article on primary malignant thymic cancer?
A. Yes.
Q. Can you tell me the names of the papers that you have published?
A. I wrote a chapter in a journal called

Chest Surgery Clinics of North America.
Q. Do you have a year, a volume or anything like that?
A. If it's in my CV --
Q. Can you identify it from your CV which is Plaintiff's Exhibit 1?
A. Yes. Reference No. 60.
Q. 16?
A. 60, 6-0.
Q. What's the year of that?
A. 1992.
Q. Any others while you are looking at your

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CV with respect to malignant thymic primary tumors?
A. No, none -- no other references.
Q. At the beginning of the deposition counsel handed me your CV, this letter with the assessment of a billing time prior to your preparation for this deposition and a notebook containing some medical records relating to Ms. Henley.
MR. BARRON: In addition, I mentioned that we were copying some records that he had reviewed here on this visit and I have a copy of that for you now.
MS. CHABER: Q. The records that you reviewed initially are in the black binder; is that correct?
A. The black binder as well as the records under your elbow.
Q. The records that are under my elbow did you review these at the same time that you initially reviewed on that first meeting records?
A. No.
Q. What records did you review on that first meeting?
A. None.
Q. When was the first time you were provided

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medical records subsequent to that meeting?
A. I believe there's a letter on the front of the binder from Mr. Sirridge.
MS. CHABER: I'd like to have that marked as plaintiff's next in order an October 30th, 1998 transmittal letter.
(Whereupon, Plaintiff's Exhibit No. 2 was marked for identification.)
MS. CHABER: Q. And is everything that is contained within the black binder the records that you reviewed sometime subsequent to October 30th, 1998?
A. Yes.
Q. And when exactly did you review the records in the binder that were federal expressed on October 30th, 1998?
A. I don't recall the date. It was in the subsequent week or two.
Q. At the meeting with Dr. Gould, Mr. Sirridge and possibly Mr. Duncan, were you told any information about Ms. Henley?
A. Yes.
Q. What were you told?
A. The meeting started off with Mr. Sirridge

and Dr. Gould and I joined them. At that point to the best of my recollection as we started to review x-rays, there was some clinical story provided.

Q. By whom?

A. By Mr. Sirridge and then we looked at some pathology slides.

Q. At the time that you joined Mr. Sirridge and Dr. Gould and prior to the time you reviewed any x-rays, were you told what Dr. Gould's opinion was with respect to Ms. Henley's condition?

A. Prior to the meeting that we had?

Q. Prior to your joining the meeting and reviewing the x-rays.

A. No.

Q. During the meeting but prior to the time that you reviewed the x-rays, were you told what Dr. Gould's opinion was with respect to what disease or diseases Ms. Henley was suffering from?

A. No.

Q. Had you heard any comments or any questions asked about whether or not this was a lung primary or a thymic primary?

A. No.

Q. When was the first time that was mentioned?

A. I believe I suggested it after having reviewed the x-rays.

Q. And what was the basis that you were suggesting it on?

A. The fact that there was no evidence -- no convincing evidence to be sure of any lung primary.

Q. And are you able to say which x-rays you base that on or which radiographs you based your opinion on at that time?

A. Well, it was based on a PA and lateral chest x-ray performed I believe in January 1998 and followed by a CAT scan in the same month.

Q. Did you review any other radiographs at the time that you concluded that this was a primary thymic carcinoma rather than a lung cancer?

A. Yes.

Q. What else?

A. There were subsequent PA and lateral chest x-rays and portable chest x-rays.

Q. Do you remember which ones you looked at?

A. I looked at all that was provided but I can't recite the dates.

Q. And do you know if the x-rays that are sitting here now which counsel has at the deposition are the same as the x-rays that you looked at or additional or some combination of the two?

A. To the best of my recollection, they are the same x-rays.

Q. Do you recall any x-rays --

MR. BARRON: Can we have a clarification? When you say additional, you mean additional for that time frame or --

MS. CHABER: Additional to what he saw on that date when he formed his opinion.

MR. BARRON: She's asking in this

envelope do we have any x-rays beyond the ones you saw at the first meeting?

THE WITNESS: I think that you've provided me with x-rays yesterday late in her course that were not presented at the initial meeting but they did not impact at all on the basis of the opinion that I had at that time.

MS. CHABER: Q. You rereviewed x-rays yesterday?

A. Yes.

Q. With counsel again?

A. Yes.

Q. Are there any notes from that review of x-rays?

A. No.

Q. And did the lawyers take any notes?

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A. Not to the best of my knowledge.

Q. And you have never written any kind of report with respect to your opinions in this case?

A. No.

Q. Have you had conversations with Dr. Gould about this case subsequent to that first meeting?

A. Oh, I believe we had some comment at lunch that it was an interesting case but really no in-depth discussion or analysis.

Q. And what about it made it an interesting case?

A. It's very unusual.

Q. And what is unusual?

A. First of all, that this lesion is so large -- this mediastinal mass is so large without any convincing evidence of pathology in the lung or primary in the lung. Secondly, the fact that it could be so big and in that location causing so much compression of the pulmonary artery and still that the recurrent laryngeal nerve apparently was left intact, was unaffected.

Thirdly, the distribution of the mass extending lateral to the aortic arch and involving the anterior mediastinum; and, fourthly, that even at the time of bronchoscopy with a six centimeter

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mass no endobronchial lesion was seen.

Q. Anything else?

MR. BARRON: Anything else what?

MS. CHABER: That made it unusual.

MR. BARRON: I just want to make sure we are talking about the same thing.

THE WITNESS: Those are the factors that I recall that caught my attention.

MS. CHABER: Q. Have you ever diagnosed or consulted on any other case where the differential diagnosis was between a small cell lung carcinoma and a primary thymic carcinoma?

A. Yes.

Q. And when was that?

A. Approximately two months ago.

Q. And where was that?

A. Rush Presbyterian Saint Luke's Medical Center.

Q. Was this a clinical patient?

A. Yes.

Q. And what was the course of disease in that person?
A. That person presented with an approximately two centimeter mediastinal node with nothing recognized in the lung on the chest x-ray or
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CT scan in which I diagnosed a small cell carcinoma in the lung at the time of bronchoscopy.
Q. And in that case you concluded that the primary site was the lung; is that correct?
A. That's my diagnosis.
Q. And had you not found a lesion when you performed a bronchoscopy, is it your testimony that you would have concluded it was a thymic primary?
MR. BARRON: Objection. The phrase, quote, is it your testimony, closed quote, is argumentative as phrased.
MS. CHABER: Q. You can answer.
A. My diagnosis in that situation would be a small cell diagnosis, a primary unknown.
Q. Why would you not under those circumstances conclude since there was a two centimeter mediastinal mass that it was not a thymic primary; why would you conclude that it was unknown?
A. Well, first of all, that the associated two centimeter mass to use your term was in the location very typical for a lymph node. And, in fact, on biopsing that turned out to be a lymph node with small cell carcinoma within it. There was nothing in the anterior mediastinum and nothing to suggest a mass apart from what was proven to be the
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lymph node.
Q. Subsequent to that first meeting with the lawyers and Dr. Gould and up to your meeting yesterday with the lawyers, have you had any other meetings with lawyers or doctors regarding the Henley matter?
A. Only phone conversations with Mr. Sirridge regarding this meeting in this case.
Q. Regarding logistics of this meeting or regarding substance of this meeting?
A. Regarding travel arrangements and logistics of this meeting.
Q. I think you said you --
A. Let me correct that because he had to provide a statement of what I believed and so there must have been some discussion with him regarding the paragraph of what I was going to be testifying about so that would be the extent of it.
Q. And have you ever reviewed that paragraph?
A. Yes.
Q. And do you have it with you?
A. I believe it's here but it's not in my possession.
MS. CHABER: Counsel, can you produce it
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before the depo is over?
MR. BARRON: I think he's probably referring to the disclosure.
MS. CHABER: I don't know what he's referring to so I'd ask you to produce whatever it

is that he's subsequently reviewed so that I can see it.
MR. BARRON: I didn't provide it to him so I can't answer but we will find out during the break. I assume it's the disclosure of expert document and I don't have that with me right at the moment.
MS. CHABER: I said before the depo is over. I didn't expect you to jump up and go get it.
Q. There are Post-its both on the side of the records contained in the black binder of what looks like from a drug company; is that correct?
A. Let me see that. That's correct.
Q. And then there are yellow Post-its at the top?
A. Yes.
Q. Did you place all the Post-its?
A. Yes.
Q. And the purpose of the Post-its?
A. To draw my attention to the page for

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quick reference.
MS. CHABER: And when we get an opportunity at the break or subsequent to, I would ask the court reporter to copy those pages which have Post-its.
MR. BARRON: Should we identify the binder as an exhibit so we know from where the Post-its came from that she's going to have copied?
MS. CHABER: Correct. I'd ask you to attach as plaintiff's next in order the table of contents from the binder.
MR. BARRON: That would be Exhibit 4, I believe.
MS. CHABER: Yeah, I think the letter is 3 and the pages contained therein as part of Exhibit 4.
(Whereupon, Plaintiff's Exhibit Nos. 3 and 4 were marked for identification.)
MS. CHABER: Now, there was a set of records that was being copied and given to me.
Q. Can you explain what these records are that are indicated in the package that was handed to me that was separate and apart from the binder?
MR. BARRON: Just to help you, we tried to assist you by creating an index, so that's what

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they are. You can get confirmation from him and you can ask him when he looked at them but that's the purpose of us providing that for you.
THE WITNESS: These were additional records that were presented to me yesterday. As the front page indicates, they are updated records from the East Valley Hematology and Oncology Consultants, updated records of Saint Joseph Medical Center and records from the Alta Bates Medical Center.
MS. CHABER: Q. And these updated records do they also include records that were contained within the binder, the documents that we've marked as Plaintiff's Exhibit 4?
A. Some of these records are in the binder.
Q. Okay. And I see that there is no -- there are no Post-its or highlighting on any of the

records in this updated records group. Did you do any highlighting or tabbing of documents within this?
A. Yes.
Q. And do you know where the copy is that had your tabbing or highlighting?
A. We went through that copy this morning and that was the only original and that's what was used for copying purposes so those Post-its were
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taken off for the purpose of copying. That's my understanding.
Q. Do you know what pages you put Post-its on?
A. No.
Q. Was there anything in these records which we'll attach the index as plaintiff's next in order that changed or confirmed your opinion in this case?
A. There was additional information in there that I found supportive of my position.
Q. And what additional information was that?
A. There is reference in there I believe to the fact that the patient had a normal voice.
Q. And what does that indicate to you?
A. That this tumor was -- that it is unusual for a tumor from the lung to involve nodes in this region and spare the vocal cord, although it -- especially when it reaches a six centimeter size.
Q. When you say it's unusual, has it ever happened in your experience?
A. I don't recall it ever happening in my experience.
Q. How many --
MR. BARRON: Let me just interject here. You asked him what he found in there I think. I
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don't remember the exact words supported or helped in any way with his opinion. I forgot the terminology. You didn't let him I think finish. You started asking questions about the first thing he mentioned. I think there are others in there. I don't want you to be misleaded about that.
THE WITNESS: There were a dozen entries of Post-its or more that I made upon reviewing those records early this morning. I don't recall right now the page number or specific information on the various pages but there was additional information in those records.
MS. CHABER: Q. That you felt were supportive of your position?
A. Yes.
Q. Just to clarify, your position is that this is a small cell thymic carcinoma?
A. My position is that this is a small cell carcinoma probably of thymic origin but possibly from some other site.
Q. And have you excluded the possibility that the other site might be the lung?
A. Not entirely excluded but highly unlikely.
Q. If it is not a thymic primary, what are
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the other likely sites?

A. We have meaning -- we meaning Dr. Gould and I have been interested in the phenomenon of primary epithelial tumors arising within nodes and it is possible this case represents such an entity.
Q. And how many of small cell tumors have you reviewed where the primary site was in the node and the tumor was diagnosed based on a mediastinal mass?
A. None that I know of but it is a diagnosis of exclusion of all other sites.
Q. And have you excluded all other sites in Ms. Henley's case?
A. No.
Q. Would it be fair to say, then, that while you believe Ms. Henley has a small cell cancer, you cannot say with any certainty what the primary site is?
MR. BARRON: Objection. The question is argumentative as phrased when you say, quote, is it fair, closed quote, and ambiguous as you used the word certainty in that question.
THE WITNESS: I don't know with any certainty where this tumor came from.
MS. CHABER: When I say certainty,

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Doctor, I'm talking about reasonable medical certainty.
Q. Do you have an opinion to a reasonable degree of medical certainty as to where the primary site of Ms. Henley's small cell carcinoma is?
A. Yes.
Q. And what is that opinion?
A. That is the thymic primary.
Q. And if I understood you correctly, earlier this would be the first small cell thymic primary that you had seen in your career; is that correct?
A. That's correct.
Q. And do you have any plans or intentions of publishing or writing about this highly unusual case?
A. I've not made any plans.
Q. And do you know -- do you have an opinion, sir, whether or not cigarette smoking causes any disease in humans?
A. I think when it comes to terminologies such as causation, that's best left to other disease entities, other issues. Today we are talking about the relationship of smoking to diseases as a risk factor rather than a simple cause and effect

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relationship.
Q. You practice clinical medicine?
A. Yes, I do.
Q. And during the course of your practicing clinical medicine do you ever discuss with a patient or that patient's family what is the cause of that individual's disease?
A. I don't use the word cause. I talk in terms of risk factors.
Q. In your clinical experience as a thoracic surgeon, have you ever had to give -- render the diagnosis of lung cancer to an individual or their

family?
A. Oh, yes.
Q. On how many occasions?
A. In my career?
Q. In your career.
A. Probably a thousand patients.
Q. And how many patients have you diagnosed where the diagnosis has been small cell lung cancer of those thousand?
A. Of those thousand, probably 200.
Q. And how many of those 200 people with small cell lung cancer smoked?
A. All of them.

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Q. And --
A. Well, may I ask you to define smoker?
Q. A person who takes a cigarette and inhales it over some period of their life?
A. And when a patient then quits smoking, are they a nonsmoker the day after they quit smoking? I'm asking you to define what a smoker is.
Q. What is your definition, Doctor, of a smoker?
A. Somebody who is actively smoking or who has quit smoking for 15 years or less.
Q. And how many of the 1,000 patients where you have diagnosed lung cancer -- strike that.
How many of the 200 small cell lung cancers that you have diagnosed over your career were smokers in your definition of smoker?
A. All but one.
Q. And with respect to the one individual of the 200 small cell lung cancers that you diagnosed over your career, did you have any opinion as to what was the cause of that person's lung cancer?
A. Now we are back to cause. There's a high correlation with smoking. It's a high risk factor in the development of lung cancer but it is not a simple cause and effect relationship.

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Q. Of those two -- of those 199 small cell lung cancers in smokers as you have defined smokers, did you ever tell any of them or their families that this was a smoking-related lung cancer?
A. I don't remember each and every conversation. I think most patients assume that that is the case but I don't believe I'm in a position to look at a patient and be able to tell them how they got a cancer.
Q. If a patient that you have diagnosed a small cell lung cancer and says to you, Doctor, how did this happen to me, do you give them an answer?
A. I tell them that they are engaging in risky behavior and the number one risk factor is smoking.
Q. How do you define cause and effect when in the clarification that you've given as between being able to tell somebody that something caused their disease?
A. Do you want me to give you an example where cause and effect would be appropriate terms?
Q. I want you to define for me what you mean by cause and effect when it relates to medical

causation?
A. I think if a patient falls out a window
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two floors and they end up breaking their leg, that that fall caused the break of the leg. If you take a hundred individuals and they take the same fall, then the vast majority of them will break something and the cause of that break is the fall. I think that there is a very clear relationship there that is not my opinion about smoking. Most people who are smokers don't develop lung cancer.
Q. What's the percentage?
A. Something on the order of 10 to 15 percent.
Q. And can you tell me what that translates to in numbers of individuals who developed lung cancer who smoke?
A. No.
Q. Those statistics of the number of lung cancers that are diagnosed each year are you familiar with those statistics?
A. Not particularly.
Q. If you wanted to know what that number is, what source would you go to?
A. Probably the American Cancer Society.
Q. Now, you were giving me an example of your definition of cause and effect and you used an incident and a result. I'd ask you to answer the
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same question what your definition of cause and effect is when you are talking about disease as opposed to an event-related thing such as a broken leg.
A. Well, at the risk of sounding argumentative trauma is certainly a disease and we study it as a disease entity that people study it as a phase of medicine in the broadest sense of the word trauma is a form of disease. Are you asking for another example?
Q. I'm asking for your definition outside the area of trauma of how you would define cause and effect with respect to disease?
A. If a patient has something like an infectious disease where an agent has been identified, a mechanism is identified and a result predictably occurs after exposure to that agent in a high percentage of cases, then there's a cause and effect.
Q. And you do not believe that that has been established with respect to smoking, sir?
A. That's my understanding.
Q. Is it your medical opinion that there is not established a cause and effect relationship between smoking cigarettes and cancer of the lung?
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A. It's my understanding that smoking is a risk factor and it is correlated with the development of lung cancer but I have not had anybody explain to me beyond simply the correlation a cause and effective relationship between that risky behavior and the development of the cancer.
MS. CHABER: Would you read my question back, please?

(Record read)
MS. CHABER: Q. I ask you the same question again.
MR. BARRON: I think he answered it.
MS. CHABER: I know you do. I don't. I think he answered a different question.
Q. Do you believe, Doctor, that it has not been established that smoking cigarettes causes lung cancer?
A. I believe that the term cause should not be used today in answering the question of the relationship of smoking and lung cancer.
Q. And what is the reason why?
A. Because the exact mechanism and an individual predictability of that behavior and the subsequent development of cancer cannot be determined with any degree of certainty.

00038

MS. CHABER: Let's take a break. We've been going about an hour.
(Short break 12:06 p.m. to 12:19 p.m.)
MS. CHABER: Q. Do you make any differentiation between a malignant thymoma and a thymic cancer or are those terms as used by you synonymous?
A. Well, I don't think the term thymic cancer is used very often. Most people talk in terms of epithelial neoplasms of the thymus benign and malignant. Malignant thymoma being probably the most common term.
Q. How many cases of malignant thymoma are reported in a year in the United States?
A. I don't know the statistics, Counsel.
Q. Would you agree that a diagnosis of a malignant thymoma is a diagnosis of exclusion?
A. No.
Q. Would you agree that the rendering of a diagnosis of primary small cell carcinoma of the thymus must be based on the exclusion of a primary tumor elsewhere?
A. Yes.
Q. And would you agree that it can be very difficult in the lifetime of the patient to

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establish a primary malignant small cell carcinoma of the thymus?
A. I think to answer your question, you can suspect. But given that until fairly recently, most people assumed that small cell carcinomas in the mediastinum had a lung primary that simply wasn't recognized, didn't even consider the possibility of small cell carcinoma of the thymus, so as an entity it really has only been raised in the differential relatively recently.
Q. Would you agree with the following statement: Small cell carcinoma of the lung is known to metastasize massively to the mediastinum at a very early stage when the primary is not detectable by radiographic means?
A. I agree with that statement.
Q. Would you agree with the statement that multiple endoscopic biopsies and cell washings or brushings are necessary to exclude the possibility

of a small or occult lung primary in the presence of bulky mediastinal disease?
A. Yes.
Q. And do you recognize Drs. Suster and Moran, M-o-r-a-n, as authorities in the field?
A. No.

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Q. Do you know who they are?
A. No.
Q. Are you familiar with the royal college of pathologists of Australia?
A. I'm familiar with the entity.
Q. Are you familiar with any publications or work that they have done on thymic carcinomas?
A. Can you repeat the authors?
Q. Suster, S-u-s-t-e-r, and Moran, M-o-r-a-n?
A. The names don't mean anything to me.
Q. Are you familiar with the Mt. Sinai Medical Center?
A. There are many.
Q. University of Miami School of Medicine?
A. Yes.
Q. Are you familiar with a Saul Suster from that facility?
A. I'm not familiar with him.
Q. Have you ever heard of him?
A. I don't recall.
Q. Are you familiar with the Armed Forces Institute of Pathology?
A. Oh, yes.
Q. And are you familiar with Dr. Cesar,

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C-e-s-a-r, Moran, M-o-r-a-n, from that institute?
A. The name doesn't ring a bell but I'm certainly familiar with the Armed Forces Institute of Pathology.
Q. And what articles, if any, do you rely on in rendering your opinion in this case?
A. I have brought some articles on the entity of small cell carcinoma of the thymus; and upon reading those, they supported my conclusion upon reviewing the records and the x-rays.
Q. Could you please produce them?
MR. BARRON: Just gather them and then --
MS. CHABER: Q. You've produced two articles?
A. I have.
Q. Are those all of the articles that you have just made reference to that you have reviewed that you believe support your position that this is probably a primary thymic tumor?
A. Articles as distinct from textbooks, yes.
Q. And what textbooks do you rely on for your opinion in this case?
A. Standard thoracic surgical textbooks, two of which would be Pearson and Sheilds.
Q. And Pearson is P-e-a-r-s-o-n?

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A. Yes.
Q. And these are two separate ones and Sheilds is the second?
A. Correct.

Q. And the articles that you have produced -- and we will copy them and attach them to the deposition as well, but I want to identify them. The first is carcinoid tumors and oat cell carcinomas of the thymus.

And I'll just read the -- they're usually identified by the first name author. The short identification of the medical article is it usually the first named author or the last named author?

A. Often the first three named authors.

Q. Okay. Rosai, R-o-s-a-i; Levine, L-e-v-i-n-e; Webber; and Higa, H-i-g-a.

Is the typical protocol of the names of authors credited to an article that the senior scientist is cited first?

MR. BARRON: Objection. The question is vague and ambiguous in terms of the phrase, quote, senior scientist, closed quote.

THE WITNESS: Practices change. In fact, the first there I believe is a chapter of a -- an annual periodical as opposed to a monthly journal

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and the practice may be different there than you would assume for an article in which case the lead author would be the most senior.

MS. CHABER: Q. And is there any typical protocol on an article as you've distinguished as between that and the manual periodical in terms of the last named author being generally the most junior?

A. I'm sorry, can you repeat the question?

Q. Let me try it over again. You distinguish between this first article being from an annual periodical and it being from a journal that is the typical publication on a monthly basis, right?

A. Yes.

Q. And you have published in the medical journals as an author?

A. Yes.

Q. Is there a typical protocol for articles that are published in medical journals as to the status of the last named author?

A. I don't believe there's a standard protocol for that.

Q. Now, you indicated that this first article that you identified came from an annual

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periodical. Is it referenced anywhere on this what periodical this came from?

A. If you show it to me, I'll see if it's mentioned. No, I don't believe it's mentioned in here.

Q. Do you know what periodical?

A. Yes.

Q. And could you tell us?

A. Pathology Annual.

Q. And do you know the date?

A. 1976.

Q. And is Pathology Annual a publication that is still being published?

A. Yes.

Q. And it comes out once a year?

A. Correct.
Q. And do you know if since 1976 and this chapter from Pathology Annual whether there have been any subsequent mention in Pathology Annual of thymic carcinomas?
A. There may have been but I didn't recall all issues of Pathology Annual.
Q. Is that something that you regularly review?
A. No.

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Q. And is this an article that you've handed me from Pathology Annual which I guess we are up to --
MR. BARRON: Six.
MS. CHABER: I think five was going to be the updated orders.
MR. BARRON: I have made an effort to try to reconstruct on what pages you originally had Post-its. They were removed for purposes of photocopying just as you were coming. I have a list of pages. I can't tell you with absolute certainty that it's entirely accurate. I think it is probably that or close to it. I'd be happy to give you those pages.
MS. CHABER: Why don't we just attach that as 5A.
(Whereupon, Plaintiff's Exhibit Nos. 5 and 5A were marked for identification.)
MR. BARRON: And you are free to -- once he looks at these pages if you want him to do so, you are free to have him look through the entire document to see if there are any others he remembers flagging with a Post-it that we didn't capture in some way.
MS. CHABER: I think he'd rather make his

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airplane today than necessarily have me do that, but I will see. I'll leave that for a later time and take your representation that you've made your best effort to reconstruct it.
MR. BARRON: And it was removal for the purposes I said rather than not letting you see where they were.
MS. CHABER: I have no doubt that it was for a benign purpose. So the pages identified would be 5A, then this is 5; is that correct?
MR. BARRON: Yeah, the entire set of records are 5.
MS. CHABER: And then the page identifier of where on your best efforts the tabs would have been will be 5A and then this article I've identified from Pathology Annual will be 6.
(Whereupon, Plaintiff's Exhibit No. 6 was marked for identification.)
MS. CHABER: Q. Do you know any of the authors that are listed in this first article Exhibit 6?
A. Yes.
Q. And tell me who you know?
A. I know Dr. Wand Rosai.
Q. How do you know him?

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A. I know him through Dr. Victor Gould.
Q. And do you have a professional association with Dr. Rosai?
A. Can you please define professional association?
Q. As opposed to a golf buddy.
A. I've never met the man.
Q. You have heard of him through Dr. Gould?
A. Correct.
Q. And is this an article that Dr. Gould recommended that you review with respect to this case?
A. No.
Q. When was the first time you reviewed this article?
A. Approximately a week ago, the first time -- it's possible I reviewed this particular article several years ago. In 1981 I was doing a great deal of reading on thymic tumors as part of a research project and I recalled that this article was out there but that was, as I say 1981, and I rereviewed it and reread it for purposes of jogging my memory approximately two weeks ago.
Q. Now, did you yourself accumulate these articles or were they given to you by counsel?
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A. Oh, no, I xeroxed -- I not only found it, I xeroxed it with my own hands.
Q. That's pretty good. Were there other articles other than these two articles -- and we will attach the second one called, "Oat Cell Carcinoma of the Thymus, Wick," and I'm not even going to try to pronounce this S-c-h-e-i-t-h-a-u-e-r a 1982 article from the journal Cancer and that would be Plaintiff's 7.
(Whereupon, Plaintiff's Exhibit No. 7 was marked for identification.)
MS. CHABER: Q. Were there any other articles that you reviewed in this time period with respect to this case which you rejected because they did not support your opinion?
A. No.
Q. Are these the only two articles 6 and 7 which you reviewed with respect to your opinion in this case?
A. No.
Q. What other articles did you review?
A. I reviewed other articles specifically documenting the distribution of tumors of the thymus glands.
MS. CHABER: And can you tell me what
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those articles -- do you have any others in your briefcase so we don't have to do this as an unveiling moment, I'm entitled to, and have noticed the deposition for him to produce all of the materials of which he read, reviewed and relied upon.
MR. BARRON: I think there may have been a misunderstanding because I think you asked him relied upon in terms of a particular opinion; and, Doctor, if there are any things that you have that you have reviewed whether they are viewed by you as

something you rely on or whether they are just something that forms the background of the case in any way or just something that you found interesting, please provide it so we don't have an issue about that.

THE WITNESS: I made reference to two standard textbooks that I rely on regularly for all kinds of things.

MS. CHABER: I don't expect you to pull those out of your briefcase.

THE WITNESS: But I made a list -- and you are welcome to this -- of three articles on Oat Cell or Small Cell Neuroendocrine Carcinomas of or Relating to or in the Differential Diagnosis of

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Thymoma. And I was able to find two and I wasn't able to find the third one. I'm still looking for that. And the four references at the bottom are as indicated in the margin, references relating to the distribution of thymomas in the mediastinum and neck.

Q. And do you have any of these articles from the document that you've handed to me which we will attach as Plaintiff's 8 with you?

A. Yes, I do.

Q. Would you provide those?

(Whereupon, Plaintiff's Exhibit No. 8 was marked for identification.)

THE WITNESS: I'm not trying to be -- I'm trying to answer the question as clearly as I can. I have four articles, duplicates of one it appears -- four articles relating to the distribution of thymomas in the chest and this is simply a duplicate of this. I'm not sure why I have two.

MS. CHABER: Okay. You've handed them to me.

Q. Are they in any particular order?

A. No.

Q. Okay.

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(Off the record)

(Whereupon, Plaintiff's Exhibit Nos. 9, 10, 11 and 12 were marked for identification.)

MS. CHABER: I'm just going to identify for the record what we have marked. I believe the last thing we identified was Plaintiff's Exhibit 8 which is a half sheet of paper with the --

Q. Doctor, this is your handwriting on here?

A. It is.

Q. -- with the doctor's handwriting of some articles, all of which he has brought with the exception of one that he is still looking for; is that correct?

A. May I see this sheet of paper? I'm sorry, would you mind showing me the articles again? I didn't check one off here. Just to be absolutely clear, I think it's just this one that I'm missing. That is correct that I am simply missing this one article.

Q. By this one article could you read it into the record so I don't have to try to make out

your handwriting?
A. It may be that this reference is inaccurate but the reference that I got is

Anticancer Research, Volume I, 1981, pages 335 to 340. That's what I'm looking for. I have found the journal but I haven't found this issue.
Q. So Plaintiff's Exhibit 8 then represents the articles that you have reviewed in connection with this case, all of which you have provided with the exception of the one you just described and which is not checked off on Exhibit 8; is that correct?
A. That's correct.
Q. Where did you get these references from?
A. I got those references from standard thoracic textbooks and I provided you with two references, two textbooks.
Q. So would the order of this have been that you went to the textbooks and then you took some references from those textbooks, put them on a list, and then attempted to get the articles themselves?
A. That's correct.
Q. And I think we had described up through Exhibit 7 of the articles. Exhibit 9 is a case of thymoma arising from undescended thymus with the first named author Fukuda, F-u-k-u-d-a, and it's an article from the European Journal of Nuclear Medicine in 1980. Exhibit 10 is Left Hilar Thymoma

Report of a Case and the first named author is Cosio, C-o-s-i-o, hyphen Pascal, P-a-s-c-a-l.
Doctor, can you identify from what journal that comes?
A. Yeah, I'm sure -- the name of the journal is called Diseases of the Chest, Volume 51, 1967, page 647.
Q. Exhibit 11 is entitled, "Thymoma Arising from Undescended Cervical Thymic," first author Ridenhour, R-i-d-e-n-h-o-u-r, from a journal called Surgery, April 1970, and the next is Plaintiff's 12.
It's called, "Intrapulmonary Thymoma," and the first author's name is Yeoh, Y-e-o-h, and it looks like it's from the Journal of Thoracic and Cardiovascular Surgery, January 1966.
Now, with the exception of the article that you have not found as of yet, do the articles that we have attached represent all of the articles that you have reviewed with respect to your opinions in this case?
A. Yes.
Q. And other than Dr. Rosai you indicated earlier do you know any of the authors of any of these articles that you have presented?
A. Yes, I know Dr. Wick. I know of Dr. Wick

to be more precise.
Q. And have you discussed with any other doctor other than mentioned a possible lunch with Dr. Gould the circumstances or facts of this case?
A. No.
Q. Are you familiar with the journal Pathology?

A. Yes.
Q. Is that a journal that you -- strike that. Are there some journals that you regularly receive in your practice?
A. Yes.
Q. Is the journal "Pathology" one of those journals?
A. No.
Q. What are the journals that you regularly receive in your practice?
A. The journal of the American Medical Association, the annals of Thoracic Surgery, the journal of Thoracic and Cardiovascular Surgery, Chest -- those are the main ones. There are additional journals that come my way on a regular basis but I don't subscribe to such as Contemporary Surgery and so on.
Q. And the journal Pathology, is that a

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recognized journal?
A. Well, they are the annals of Pathology and the American Journal of Pathology. I'm not familiar with one called simply Pathology. I thought of another one, the Chest Surgery Clinics of North America.
Q. Just for the clarification of the record plaintiff's next in order, which would be 12, will be the notice of the deposition. We can do that afterwards.
MR. BARRON: I'm sorry, I thought the last article was 12.
MS. CHABER: Oh, I thought it was 11. 12.
MR. BARRON: Basic math.
MS. CHABER: You are correct. The notice of deposition would be 13 if I am getting my numbering sequence correct.
Q. In your review of the materials in this case, including but not limited to, the radiographic materials, was there any evidence indicating a mass in the interior mediastinum?
A. Yes.
Q. Okay. Can you tell me which materials, whether it's records or radiographs, indicate a mass

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in the anterior?
A. There is an x-ray report and I read an x-ray -- chest x-ray and CAT scan that showed involvement of the anterior mediastinum.
Q. And could you identify those, please?
A. Sure.
MR. BARRON: It's about ten of. Do you want to take this time to have lunch and sort out these x-rays?
MS. CHABER: That would make sense.
THE WITNESS: I notice there is from time to time another observer. How are we going to do x-rays so he can see?
MS. CHABER: That's Bill's problem.
MR. BARRON: We will figure out something.
THE WITNESS: I would be glad to put it on the table.

MR. BARRON: It's not good during the whole deposition because the court reporter is aided by watching it.
MR. OHLEMEYER: So don't worry about me.
MR. BARRON: We can do that. We will see. We can pull those out and look for them and let's go get some lunch.

MS. CHABER: Okay.
(Lunch from 12:52 p.m. to 1:27 p.m.)
(Mr. Ohlemeyer exited video conference)
---oOo---
AFTERNOON SESSION
MS. CHABER: Q. Dr. Warren, did you have discussions with any of the attorneys during the break over lunch?
A. Not in reference to the case here. Obviously discussed the pleasantries of San Francisco but we didn't discuss anything to do with the deposition or this case.
Q. Nothing with respect to any of the questions that had been asked of you or any of the answers that you may have given?
A. No.
Q. Can you tell me what the cause of primary thymic carcinoma is?
A. I don't know.
Q. Can you tell me what the incidence of malignant primary thymic carcinoma is?
A. I couldn't give you a statistic but it's an unusual tumor.
Q. Can you define unusual for me?
A. Uncommon.

Q. Is there some percentage or number, you know, that you could ascribe to it, less than one percent, you know, whatever?
A. Probably less than one percent of all tumors in the body recorded in the year.
Q. And what is the incidence of a small cell primary thymic carcinoma?
A. It is an unusual cell type for a thymoma to have.
Q. And can you tell me in some numerical or percentage fashion how many tumors in the body presenting in a year present as a primary small cell thymic carcinoma?
A. I would only be guessing. But since only one percent is thymomas and this is an unusual histology of thymoma obviously much less than one percent.
Q. Do you know how many cases in the worldwide literature of primary small cell thymomas have been presented?
A. I think I have to be careful here because this is a new entity. This is an entity that is uncommon. It is an entity that many people assume is related to an occult pulmonary primary and many people are not interested enough in the subject of

the source of the primary to pursue it.
So it may well go under reported. But if you asked how many cases are in the literature, I

would think probably on the order of under 50 cases reported as proven thymic small cell and exclusion of other sites often requiring an autopsy to be certain.

Q. And can you tell me what the incidence of small cell carcinoma of the lung is?

A. As a number I can't give you the number. It represents approximately 20 percent of all primary lung cancers.

Q. Do you know if there is a greater or lesser percentage of small cell primary lung cancers in women than in men?

A. The statistics on that, as I recall, are changing because the incidence of lung cancer in women is rising. I would assume that the incidence of small cell carcinoma in women is rising, too, but I can't quote you any statistics.

Q. As histologic type of lung carcinoma in women, do you know what percentage are small cell carcinomas?

A. It's approximately the same today. In the literature they suggested that it was an -- in

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the literature of the '70s, they suggested that small cell carcinoma of the lung was uncommon, but that's no longer true.

Q. Have you seen literature of today that indicates that as between men and women small cell carcinoma is found to a greater percentage as a percentage of total lung cancers in women than in men?

MR. BARRON: I'm going to object to the question as being ambiguous.

THE WITNESS: I don't understand the question.

MR. BARRON: That's why I objected. I had trouble with it also.

MS. CHABER: Q. Are you familiar with the differences in identification of cell type of lung cancer in men and women?

A. Yes.

Q. And what is that that you are familiar with?

A. Adenocarcinoma tends to occur more in women than men. That is a tendency but that the incidence of small cell carcinoma men versus women have stayed both the same.

Q. In women with lung cancer, the greatest

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percentage of them have what cell type?

A. Adenocarcinoma.

Q. And what's the next cell type, next greatest percentage?

A. Probably squamous carcinoma.

Q. And what would be the next greatest percentage?

A. Probably small cell carcinoma and large cell carcinoma. There are different criteria for what pathologists would call large cell versus adeno so the statistics change from different reports.

Q. What percentage of lung cancers of the small cell type spread to the mediastinum?

A. Repeat the question, please.

Q. What percentage --
MS. CHABER: Read it back.
(Record read)
THE WITNESS: Are you talking about in the course of the disease or at the time of presentation? I'm confused.
MS. CHABER: Fair enough.
Q. At the time of presentation what percentage of lung cancers present with a hilar mass?
A. That's a different question.

00062

Q. I understand. I changed my question.
A. I sure am glad I objected. What percentage of -- please repeat the question.
(Record read)
THE WITNESS: All lung cancers? I'm asking for clarification on that. What percentage of all lung cancers present with a hilar mass; is that the question?
MS. CHABER: Q. That's my initial question.
A. 40 percent.
Q. And what percentage of small cell lung cancers present with a hilar mass?
A. Let me just suggest that the term hilar mass is one that is used rather loosely in medical terms. And that if it is sort of central in the lung, it is sometimes referred to by radiologists as hilar.
As a surgeon the hilar mass is something quite specific and something quite different that a radiologist may refer to the hilum generally to something central in the lungs so with that clarification I would suggest that more than half of the small cell carcinomas have pathology in the region of the hilum.

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Q. In a woman with a left hilar mass and a 75 to 122-pack-year smoking history, what would be the most likely diagnosis?
MR. BARRON: Can I have that reread?
THE WITNESS: Would what be the most likely diagnosis?
MS. CHABER: Q. The question is, what would be the most likely diagnosis?
MR. BARRON: I'm going to object to the form of the question as being ambiguous and potentially unintelligible as not containing enough predicates to allow a meaningful answer.
MS. CHABER: Q. Go ahead.
A. Can you repeat the question again?
Q. In a woman with a left hilar mass and a 75 to 122-pack-year smoking history, what would be the most likely diagnosis?
MR. BARRON: Same objection on the basis that it's a hypothetical not containing enough information and it's ambiguous.
MS. CHABER: Q. Go ahead, Doctor. You started to answer.
A. In taking the question very literally as you have suggested, probably the most likely diagnosis is some form of lung cancer.

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Q. And do you know what the most common cause of lung cancer is?
A. Well, we are getting back to the issue of causation. I think that the most important risk factor is smoking.
Q. Are there any risk factors that are associated with a primary small cell thymic carcinoma?
A. Not that I'm aware of.
Q. Is there any predisposing characteristics of a person with a primary thymic carcinoma of the small cell variety?
A. Not that I'm aware of.
Q. What percentage of lung cancers originate in the mediastinum?
A. None.
Q. At presentation?
A. None.
Q. What percentage of lung cancers where there is mediastinal involvement -- strike that.
What percentage of lung cancers have mediastinal involvement?
A. Again, I need clarification. Are you talking about on the course of the disease in an autopsy series at the time of presentation to a
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surgeon, at the time of presentation to a family practitioner, the numbers will change dramatically so I need clarification.
Q. Why don't you go through the -- those things that you've just indicated would affect the answer to that and you can break them down by origination course --
MR. BARRON: Let her finish. Are you finished?
MS. CHABER: Etc.
MR. BARRON: Why don't you try rephrasing it. I think that's ambiguous and unintelligible and maybe calls for a narrative and he seems to be a little bit lost anyway because he was about ready to ask for a clarification. I think you can probably break that down.
MS. CHABER: Q. What percentage of small cell lung cancers present with a mediastinal mass?
THE WITNESS: I need clarification on such things as mediastinal mass because that can be a variety of things. So if you can -- if you can elaborate a little bit more, I'd be glad to answer your question.
MS. CHABER: Q. Tell me what the different things a mediastinal mass can be.
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A. A mediastinal mass could be anything. The mediastinum is a complex structure. It represents everything between the lungs. It can be a mass that is in the posterior mediastinum against the spine.
It can be in the anterior mediastinum behind the sternum. It can be mediastinal nodes in the middle of the mediastinum. Chapters and textbooks are written on the differential diagnosis of pathology and masses in the mediastinum, so

that's why I'm asking for clarification.
Q. What percentage of lung cancers of the small cell variety present with a mass in the anterior mediastinum?
A. Very unusual, less than 10 percent, probably less than 5 percent.
Q. Have you ever seen any lung cancers of the small cell type that have presented with a mass in the anterior mediastinum?
A. I can't remember a single case.
Q. Do small cell lung carcinomas grow from the lung outward?
A. Please define outward. They grow and they will grow in all directions. I don't understand what you are saying.

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Q. Do small cell lung carcinomas grow in the direction of the invasion of the tissue outside the lung as opposed to growing further into pulmonary lung tissue?
MR. BARRON: Again, I need to object. I think the question's ambiguous because of the use of the phrase do they grow. It's unclear to me whether you mean is it possible that they grow in that way.
Are you saying do they always grow in that way? Do they sometimes grow in that way? Do they usually grow in that way? It's ambiguous as phrased and could be misleading for you to reply without that objection.
MS. CHABER: Q. Can you answer?
A. Tumors grow in two ways. They grow by direct spread and they grow by establishing metastatic disease. Small cell carcinoma is quite good at doing both.
Q. When small cell carcinoma spreads by direct spread -- when small cell lung carcinoma spreads by direct spread, does it tend to spread more frequently outward through the lung tissue, through the pleura and into other organs or inward?
MR. BARRON: Objection. Ambiguous.
THE WITNESS: I agree in your terms of

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inward and outward. I mean, what you are defining as in and out, they are not anatomic terms, so I think I know what you are trying to say, but I want you to ask me a question that I'm clear on.
MS. CHABER: Q. What do you think it is that I'm trying to say in the correct terminology, Doctor?
A. I think that lung cancer -- that small cell lung cancer of the lung tends to grow by direct spread and is particularly good at growing by establishing metastases particularly through the lymphatic channels.
And the lymphatic channels can overshadow the direct spread in the lung, that the tumor in the lung may be overshadowed by the involvement of nodes. You talked about pleura and that could be up, down, back, front, out, in.
So, you know, to be clear, outward spread doesn't mean anything when you are deep in the chest. If you mean radially growing by direct spread, it could be growing inward as well as

outward, so that's why I'm confused in what you are asking me.
Q. Do the greatest percentage of small cell carcinomas of the lungs originate in the distal
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airways?
A. No.
Q. What is the origin of the greatest percentage of small cell carcinomas of the lung?
A. I don't know that, but I can tell you that most of them -- the tumor itself is found as a central mass rather than a peripheral mass.
Q. Do you know the number of deaths each year due to lung cancer?
A. I can't recite that to you.
Q. Do you know the number of deaths each year due to primary thymic carcinoma?
MR. BARRON: I need to object to the due to. We've had quite a dialogue, twice actually on the record on the issue of causation and risk factors, so I think your question of due to is ambiguous, and it's unclear whether you mean attributed by other people to that or whether you are going to a particular statistic or just what?
MS. CHABER: Q. Doctor, there is an incidence of death per disease type reported in this country by year; is there not?
A. Yes.
Q. Can you tell me what is the incidence of disease type of lung cancer deaths per year?
00070
A. I'm sorry, I don't understand your question.
Q. How many deaths per year are reported due to the person dying from lung cancer?
A. Something in excess of 200,000 cases a year but that's a guess. I don't recall statistics.
Q. Do you know what the number of deaths per year is of a person dying from a primary thymic carcinoma of the small cell type?
A. It's a rare disease so I have to assume that it is a few cases a year, no more.
Q. Less; it could be no cases in a given year?
MR. BARRON: Hold on. Objection as to the phrase could as being ambiguous in terms of calling for pure possibilities or some higher measure of incidence.
THE WITNESS: I have testified earlier today that this disease tends to go unrecognized because people assume without any proof that there is a lung primary and some people aren't even aware of the existence of this lesion, so the statistics may well be misleadingly low, but it is certainly much less frequent than small cell carcinoma of the lung.
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MS. CHABER: Q. And where would it be reported how many small cell carcinomas of the primary in the thymus from which the person died, where would I go to find that information?
A. To be honest with you, I don't know. I would start probably with the American Cancer

Society but they simply keep records as reported to them and for the reasons I mentioned above it's likely to be underestimated.

Q. Now, I thought I understood you earlier that these articles that you had presented, one of the things that you were looking up was the incidence of primary thymic carcinomas?

A. No, that's not what I was referring to the articles for.

Q. What was your purpose -- what were you looking for in looking up these particular articles that we've -- that you've produced here today Exhibits 6 through 12?

A. One is method of presentation and location, clinical course.

Q. One was method of presentation; two was?

MR. BARRON: Location.

MS. CHABER: Location.

Q. And three was clinical course?

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A. Yes.

Q. In Exhibit 6, "Carcinoid Tumors and Oat Cell Carcinomas of the Thymus," first, let's clarify. Is oat cell carcinoma the same thing as a small cell neuroendocrine carcinoma?

A. Colloquially speaking, yes, I think the term oat cell carcinoma should be dropped and a more accurate term is small cell neuroendocrine carcinoma.

Q. As you understand the article by Rosai, was he using the term oat cell carcinoma as synonymous with small cell neuroendocrine carcinoma?

A. That's my understanding.

Q. And do you agree with his statement that a primary thymic oat cell carcinoma will necessarily remain a diagnosis of exclusion only verifiable at the autopsy table?

A. I believe at the time he wrote that that was true.

Q. And --

A. That was over 20 years ago.

Q. Okay. In your opinion that has changed subsequently?

A. I think that that statement is too strong for 1998.

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Q. Do you have any articles here from 1998?

A. You have every article that I brought. There's nothing in my bag.

Q. Article 7 called, "Oat-Cell Carcinoma of the Thymus" by Wick, etc.

A. Is that a question?

Q. I was looking for a hint of recognition that you were recognizing the article before I went on with the question.

A. I provided that article to you.

Q. Okay. Were the authors using oat cell carcinoma as synonymous with small cell neuroendocrine carcinoma?

A. That's my understanding.

Q. And do you agree with their statement as the first statement in the abstract, quote, "Oat cell carcinoma of the thymus gland is exceedingly

rare as a primary lesion and only a few cases have been reported"?
A. That's a true statement.
Q. And the case that they were reporting about was a case that arose in transition from a carcinoid tumor of the thymus?
A. That's what they reported.
Q. And carcinoid tumor of the thymus is a

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nonmalignant tumor?
A. No. That's a malignant tumor.
Q. Is it of a different nature than a different cell type?
A. It's of the same cell type.
Q. Is it of a different location?
A. No, it's the same location.
Q. What's the difference between a carcinoid tumor of the thymus and an oat cell carcinoma of the thymus?
A. Histologic pattern and clinical course. They are different tumors.
Q. And what is the clinical course of a carcinoid tumor of the thymus?
A. It is a slow progressive malignant course with local extension and systematic metastases.
Q. And the oat cell carcinoma of the thymus, what would you describe the clinical course?
A. It is more aggressive than carcinoid, but from the case reports I reviewed not as aggressive as the typical small cell neuroendocrine carcinoma of the lung.
Q. Are you familiar with the tumor grading level, low grade, high grade?
A. Yes.

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Q. Is an oat cell carcinoma of the thymus a high grade carcinoma?
A. Yes, it is.
Q. And in your opinion describe for me what you mean by high grade?
A. Perhaps I should caution counsel about the use of the term grade in pathology that, for instance, adenocarcinoma of the colon can be low, medium or high grade malignancy.
It is the same tumor with different histologic features that reflect its degree of aggressiveness. It is the same tumor. They are described the same. They are all adenocarcinomas of the colon but they can be of different grades.
In this use of the word grade, they are simply saying that it is a very aggressive tumor. The reason that this article is particularly interesting is the coexistence of two different tumors.
One happens to be a less aggressive tumor and one is a highly aggressive tumor and they are using the term high grade as synonymous with a highly aggressive tumor.
Q. In this article weren't the authors concluding that the high grade oat cell carcinoma

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was a tumor that had transitioned from the carcinoid tumor which was the earlier presentation?

A. I don't recall that they made that conclusion but I don't believe that that is true.
Q. And this paper by Wick Exhibit 7 was a report of one case, correct?
A. That's correct.
Q. And the person was a 25-year-old person, correct?
A. I don't recall the age of the patient.
Q. Okay. It would be reported -- you would accept it if it was reported in the paper that the person was 25 years old?
A. Of course.
Q. And that the person was a never smoker?
A. I would accept that.
Q. And you would agree with the physicians in his reported case that it would be highly unusual for this individual to have a lung carcinoma due to his young age and his not having been a smoker?
MR. BARRON: I'm sorry, could you read the question back?
MS. CHABER: Read it back.
(Record read)
MR. BARRON: Are you quoting from what

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you called the physicians? If so, I think you ought to accurately --
MS. CHABER: I wasn't quoting. I was asking whether he agreed with that interpretation of this report Exhibit 7.
MR. BARRON: Just so I have the question, are you asking him whether he --
MS. CHABER: Counsel, make a legal objection, please, instead of coaching the witness as to where you want the question to go. I think I asked a question. I'd like him to tell me if he can answer it. Were you able to answer the question?
MR. BARRON: I was trying to shortcut it. I'm not trying to coach him. I'll object on the basis that your statement contains something to which there's been no foundation the statement about the physicians without showing him a portion of the article upon which he may or may not be relying for that foundation.
MS. CHABER: Q. Can you answer the question?
A. It is unusual for a 25-year-old to develop lung cancer but I have seen it. I have seen it in a patient as young as 16 years old. It is unusual for a patient to develop lung cancer as a

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lifetime nonsmoker but that incidence is not negligible and is rising.
Q. And what is the incidence of someone 25 years old or younger and a nonlifetime nonsmoker developing lung cancer?
A. I would have to assume that it is very unlikely.
Q. And this article from a Cancer magazine in 1982 did you note that it indicated that to the best of their knowledge -- the author's knowledge that there were only two previous reports of primary oat cell carcinoma in the literature?
A. I would respectfully suggest that the

journal of Cancer is not a magazine but apart from that the fact that two cases they identified in the literature is -- you have the paper in front of you -- quite possible; but, again, I believe that this entity goes underdiagnosed.

Q. Do you have any articles, citations to authority and textbooks that say anything different than what the authors of the article in Cancer magazine stated; that is, that there were only two previous reports of primary mediastinal oat cell carcinomas in the literature?

A. That's a long question. Can you please

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repeat it?

(Record read)

THE WITNESS: Can you please simplify the question? I accept what the authors are saying in this article a long time ago.

MS. CHABER: Q. That at that time that they wrote the article in 1982 were only two reported cases of primary mediastinal carcinoma of the oat cell variety?

MR. BARRON: You've got to let her finish. We are getting too fast. I know there's some anxiety on both your parts to try to communicate on this issue.

MS. CHABER: I'm trying to hurry to get him out of here.

MR. BARRON: No criticism here. Since we are trying to be as precise as we can for your benefit and for his as the witness, I want to make sure that we don't mistakenly communicate. So slow down and let her finish. And if she had finished, let's have the court reporter read it back. And if you understand it, answer. If you need clarification, ask for the clarification.

(Record read)

MS. CHABER: Q. Doctor, would you agree

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that at the time that Wick wrote this article on oat cell carcinoma of the thymus in the journal Cancer in 1982 there had only been two reported cases of oat cell carcinoma primary mediastinal site reported in the literature?

A. No.

Q. Can you cite me to any other articles or written authorities that would establish your answer that there were not only two reported in the literature in the time of 1982?

A. I believe it's right in front of you, Counsel; namely, the other article which was written six years previously where there's a whole chapter on pathology annual.

Q. And the article you are referring to is this the Rosai article?

A. That's correct.

Q. And the authors did discuss the Rosai article in this paper in the journal of Cancer?

A. Yes.

Q. And they noted that all six cases reported by Rosai had been studied at autopsy?

MR. BARRON: At some point here we provided these articles to you. If you're going to

question him phrase by phrase or paragraph by

paragraph, I think in fairness rather than you summarizing it, we ought to provide him a copy so that --

MS. CHABER: If you want to take the time. I didn't know that you don't have other copies of this.

MR. BARRON: Are you going to spend some time with that article?

MS. CHABER: I'm going to spend time with all of them.

MR. BARRON: Okay. We will get something run off.

MS. CHABER: Why don't you let me ask my questions of him and then if he needs to refer to an article, we will put those questions aside for the time being. He may be able to answer some of these without reference to it.

MR. BARRON: That's fine. Make sure, though, that you listen to the language carefully because we are not going to be sure whether she's attempting to summarize or is quoting and she wouldn't do it intentionally but in summarizing, she may miss out an important term or concept that's of physiological importance. Okay.

THE WITNESS: I understand.

MS. CHABER: Q. Doctor, do you recall whether or not the individuals reported in this article in the journal Cancer to have oat cell carcinoma of the thymus had another primary tumor in his pancreas?

A. I recall that.

Q. Dr. Warren, isn't it true that surgical excision is the primary treatment for thymoma?

A. Not all thymomas lend themself to complete surgical excision so I'm going to disagree with your statement.

Q. Is surgical excision whether it is complete or not complete the primary treatment of thymoma?

A. No.

Q. What is the primary treatment?

A. I think that you have to determine in this case if you are talking about all thymomas or malignant thymomas.

Q. We are talking about malignant.

A. The vast majority of malignant thymomas are not completely resectable.

Q. And the percentage of malignant thymomas to nonmalignant thymomas is what?

MR. BARRON: We've gone through that before. He made some estimates.

THE WITNESS: The majority of thymomas are not malignant.

MS. CHABER: Q. What is an undescended thymus?

A. The thymus gland arrives -- derives embryologically from tissue at the back of what becomes the throat and it descends in development to a location behind the breast bone in the majority of

cases. In some cases it descends further down and in other cases there are tissue remnants left up in the neck.
Q. What is a cervical thymoma?
A. It is a thymoma found in the neck.
Q. And do cervical thymomas present with left hilar masses?
A. By definition the cervical lesion is in the neck.
Q. And the article No. 9, "A Case of Thymoma Arising from Undescended Thymus," can you tell me what in this article you felt was significant with respect to this case -- Ms. Henley's case?
A. Only to read the article with respect to the variety of locations of thymoma apart from the anterior mediastinum or shall I say not limited to
00084
the anterior mediastinum.
Q. The case that's reported in Exhibit No. 9 that is not a case of which the differential diagnosis would be a lung carcinoma, correct?
A. I don't believe that was the differential diagnosis in this case.
Q. And the location of where that tumor presented in Exhibit No. 9 is distant from the lungs, correct?
A. Correct.
Q. Exhibit No. 10 "Left Hilar Thymoma Report of a Case" from Diseases of the Chest 1967. That's a report of one instance -- or rather it's a case report?
A. It is.
Q. And in that case the individual was 18 years old?
A. I don't recall.
Q. Is this case set forth in Exhibit 10 a small cell thymoma?
A. It didn't use that language in describing this. The Xerox is quite bad unfortunately but the term small cell or oat cell carcinoma was never mentioned in the differential. However, it's important to note that this did have pseudorosettes
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which is a pattern that is often found in neuroendocrine tumors, although not necessarily small cell carcinoma.
Q. What about that article Exhibit No. 10 did you find significant for this case -- Ms. Henley's case?
A. First of all, the location of the tumor which was at the left hilum; and, secondly, that it makes reference to other tumors, other thymic tumors that were also found at the left hilum.
Q. And are those malignant tumors that were found that you just made reference to?
A. I didn't read the articles that this article in turn referred to.
Q. And there's no reference there in the article itself as to whether those authors are referring to malignant thymomas?
A. I believe that's true.
Q. Can you tell me any other articles in the literature of a malignant thymoma --

A. I'm sorry, I was thinking of something else. Can you please start again?
Q. Can you tell me of any other articles reported in the literature of a malignant thymoma of the small cell type arising in the left hilar area?

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A. No, not offhand.
Q. In Article 11 entitled, "Thymoma Arising from Undescended Cervical Thymus," what was it in this article that you found significant for your opinions in the Henley case?
A. Only the documentation that thymomas can be found in locations other than limited to the anterior mediastinum. There are again interesting comments made in a discussion in the references that I found interesting but I wanted to get into the literature for the distribution of thymomas.
Q. And what is the distribution of malignant thymomas?
A. The same as benign thymomas and that is that the majority are found in the anterior mediastinum. Some are found in the neck. Some are found in the hilum. They have been found as low as on the diaphragm and they have been found within the lung.
Q. And do you know the incidence of primary anterior mediastinum small cell carcinoma?
A. No.
Q. I think before we took the lunch break, we were about to discuss the x-ray and CT scan that I believe you indicated was a part of your support

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for your opinion that this is a primary thymic carcinoma?
A. Is that a question?
Q. Can you tell me first in words and then we can look at the x-rays -- obviously you can be looking at them when you put it into words -- what it is about the x-ray and CT scan that you identified before lunch as indicating support for your opinion that this is a primary thymic carcinoma?
MR. BARRON: I'm going to object on the basis that it calls for a narrative. He's prepared to talk about a lot of details on both and I don't mind him giving just a very general overview statement if it's possible but in order to answer that question, you are going to have to allow him to go film by film and tell what he does or doesn't see.
MS. CHABER: I don't know if it calls for a narrative in a deposition.
MR. BARRON: I think it could.
THE WITNESS: Would you like me to interpret the x-rays?
MS. CHABER: Sure.
MR. BARRON: That's what I was

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suggesting.
MS. CHABER: I want you to identify which ones and then as you identify them, I would ask you to indicate which report it is that corresponds to the actual report at the time.

Q. Do you understand what I'm asking?
A. I would be glad to read the x-rays and I believe that there's a report here of a radiologist's interpretation as well.
Q. Okay.
A. This is a PA and lateral chest x-ray of Patricia Henley dated January 3rd, 1998, PA and lateral chest x-ray.
Q. And what is the facility?
A. Saint Joseph Medical Center in Burbank and on the PA chest x-ray there is a fullness or, shall we say, a silhouette part of a bump here that is abnormal.

It corresponds to the junction of the lung and the mediastinum generally known as the hilum and it is abnormal. It is clearly abnormal. I don't see anything else beyond that including anything clearly within the lung or anything to suggest that the lung is involved in this other than it is, as we say, in the junction of the lung and

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the mediastinum.

On the side-view the breastbone is anteriorly, the spine is posteriorly located. This is the heart shadow and this is the mass in here and you can see that it is generally speaking in the center of the chest.

But that it does extend anteriorly into the retrosternal airspace which is generally known as the anterior mediastinum. In addition, on the lateral film you see nothing to suggest an underlying pulmonary lesion infiltrate underlying pulmonary pathology.
Q. Could you cite me to the x-ray report that corresponds to the x-ray that you have just read?
A. Yes. I believe that -- I don't know if I can take the --
Q. You can take it out and hand it across.
A. It happens that it seems to be a duplicate here in my chart as both pages 34 and 35. I think it's just a duplicate of the same thing.
Q. Can I see that for a second?
A. Surely.
Q. Put that back in your book. Then there was a CT scan on the same day?

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A. Correct. Do you want me to -- I'm pointing out simply that --

MR. BARRON: She's in charge of what she wants to find out about.

MS. CHABER: Q. You are pointing out simply what, Doctor?
A. I want to indicate in this report that the radiologist acknowledges that the soft tissue density is evident in a portion of the retrosternal space.
Q. Okay. And also that the left hilum and the left upper mediastinum appear abnormally prominent, correct?

MR. BARRON: That's what the rest says.

MS. CHABER: That's the rest of that sentence.

MR. BARRON: The document speaks for itself.
MS. CHABER: That's not an objection, Counsel.
THE WITNESS: The document speaks for itself. I don't take issue with this interpretation.
MS. CHABER: Okay.
Q. And there was a CT scan done on the same day?
A. Yes.
Q. And you have that CT scan available?
A. Yes.
Q. Could you put that up?
A. For the record there are obviously one, two, three, four, five, six, seven, eight panels and I am choosing two that are the most relevant to the comments that I'm going to make of the entire scans.
Q. This CT scan on January the 3rd is what would be called a conventional CT scan rather than a high-resolution CT scan; is that correct?
A. That's correct.
Q. And the images that were attained were 10 millimeters apart?
A. That's correct.
Q. And can you identify which frames or which sheets you have put up?
A. I put up the mediastinal windows from Images No. 1 plus C to 24 plus C.
Q. And is that on all -- on both --
A. Image 1, C2, C3, C4, C5, C6, 24C -- C meaning being contract -- has been added and that's what's showing in this.
Q. And the black space surrounded by ovals that we see in the picture is the lungs?
A. This is the right lung and this is the left lung.
Q. And can you point out and tell me which contrast you are referring to where the mediastinum is?
A. The contrast is given in the right arm and lights up all the vessels, the vessels that are in the mediastinum. The mass is in the mediastinum and so --
Q. We need an identifying number of which window you are talking about, Doctor, so can you identify for me where the mediastinum is and identify which window you are pointing it out to me in; did that make sense?
A. I think so. The mass extends from at least Image 7 plus C down to and including 13 plus C.
Q. Can you tell me which window would be the best window to view for seeing the superior segment of the left lower lobe?
A. None of these windows which are mediastinal that is in other images, lung windows, not the mediastinal windows.
Q. What is your interpretation of the mediastinal windows that you selected to

demonstrate?
A. It simply demonstrates the size, the location, and the extent of the mass of the left hilum and mediastinum.
Q. And where is the main stem bronchus in those windows?
A. The right or the left main stem bronchus.
Q. The right?
A. It's right here.
Q. And that's window?
A. Well, it's seen in Images 11, 12, 13, I suppose, and 14.
Q. And is the mass that is seen extending into that area of the right main stem bronchus?
MR. BARRON: I'm sorry, could you read the question back?
(Record read)
THE WITNESS: It is extending to the very origin of the right main stem bronchus in Image 11C, but it does not involve the right main stem bronchus itself.
MS. CHABER: Q. And how can you determine that?
A. Because I can see the mass as being a

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different density than the main stem bronchus in identifying those two entities. I can see that they are in proximity but I don't see any further extension.
Q. Now, was there anything else you wanted to point out in your review of the windows that are up there?
A. Well, there are many things that I can talk about. Did you have a specific question?
Q. I asked you to interpret them. I thought that's what you had indicated you were doing.
A. I want to -- I have identified those windows that demonstrate this rather large left hilar mass which is multilobulated, which extends into the anterior mediastinum, best seen on Image 7C, possibly even 6C, although I'm less certain of that.
It extends lateral to the aortic arch and spares the subcorinal and paratracheal nodes and that it extrinsically compresses almost completely the left main stem -- the left main pulmonary artery and it extensively abuts the entire left main stem bronchus including beyond the bifurcation.
Q. What is the significance of that; it includes beyond the bifurcation?

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A. I'm simply describing the extent of the mass.
Q. Okay. Is there any significance to it being multilobulated?
A. This is --
Q. And let me ask it this way: Is there any significance between a differential diagnosis of lung cancer and primary thymic cancer to it being multilobulated?
A. I think that the fact that the contour of this tumor is smooth and that portion of the tumor that is interfacing with the lung is so clearly and

smoothly defined make it less likely that this is a lung tumor growing into the mediastinum than a mediastinal tumor abutting the lung.

MS. CHABER: Could you read the answer back, please?

(Record read)

MS. CHABER: Q. What is your basis of that statement?

A. My experience.

Q. Is there anything in the report and literature that indicates that a smooth contour of a tumor in the location you've described makes it less likely to be a lung tumor than a primary thymic

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tumor?

A. Well, you are asking a very specific question. It is true that if something has a smooth contour, that it tends to be within a capsule or within some anatomic structure.

In this particular case if something were in the lung and growing, it is less likely when it gets to this size that the advancing margin would be so well demarcated in contrast to the thymus which this may well represent a malignant tumor of the thymus still within the capsule.

Q. I was interrupting you.

Have you concluded your reading of those windows that are up on the screen then?

A. I may be just repeating myself but the mass extends fairly extensively lateral to the aortic arch but spares almost completely the paratracheal region and I believe I said that before but I just wanted to make sure.

Q. What's the significance of that?

A. Lymph nodes tend to be located in the paratracheal region and not lateral and superior to the aorta.

Q. And tell me what the mechanism is that you are talking about that relate to lymph nodes is

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with respect to the growth of this tumor?

A. I'm simply stating anatomic facts. The distribution of lymph nodes in the mediastinum does not correspond -- it does not correspond at all to a tumor being lateral and superior to the aortic arch extending into the anterior mediastinum. That is not the distribution of nodes. That may well be the distribution of an anterior mediastinal mass that has involved the left hilum.

Q. And what would be the likely course of a lung tumor growing into the mediastinum?

A. The likely course would be the involvement of lymph nodes at Level 5, possibly Level 6 and extending up the mediastinum through Levels 7, 2, 3, and 4 with continued extension up to superclavicular nodes and systemic metastases.

Q. Have we concluded with your review now?

A. Of these panels, yes.

Q. Were there other panels within the CT scan that you believe support your position that it is more likely that this is a primary mediastinal tumor?

A. Shall we take a break?

MR. BARRON: I'm just getting some air in. I'm breathing more carbon dioxide than I wanted to.

THE WITNESS: Well, I would be glad to read these films. There are other images that support my statements.

MS. CHABER: Q. Can you just tell me what those images are and what it is in those images that support your statements?

A. I think these are probably the best images to demonstrate the findings on which I base my conclusions but I can certainly direct you to other images such as Image 164 and 169, 159, 154, 149, 144, 139, 134, 120 and 129.

Q. And is there anything in those --

A. Without a contrast.

Q. Okay. And is there anything in those images that you have just identified that is different support than the things that you've previously described such as the smooth contour and so forth?

A. Some of those images pertaining to the lung windows as opposed to the mediastinal windows are important for the absence of findings.

Q. And which ones are those?

A. They are the same numbers -- well, inasmuch as I'm talking about an absence of findings, I'm going to say all of the lung windows because none of them demonstrate a lung primary in my opinion.

Q. And which is the window or windows that best demonstrate the superior segment of the left lower lobe?

A. Those windows would be 169, 164, 159, 154, 149. These particular windows are 5 millimeter cuts in contrast with the previous scans which were 10 millimeter cuts as you correctly identified them.

Q. And is that higher resolution or lower resolution?

A. The resolution would be the same. The cuts would be thinner.

Q. And does thinner cuts allow you to identify smaller anatomical findings?

A. Yes.

Q. And do you see an infiltrate in the superior segment of the left lower lobe?

A. Yes, there are changes in the superior segment of the left lower lobe.

Q. And what do you account for those changes?

A. That's a very nonspecific finding. It is very diffuse and it is very subtle.

Q. Well, given your opinions in Ms. Henley's case and having reviewed all of her records and x-rays, what would account for there being diffuse subtle infiltrate in the superior segment of the left lower lobe?

A. She could have a mucous plug.

Q. Could she also have a small cell carcinoma?

A. I suppose it's within the realm of possibility but extremely unlikely.
Q. Why is it extremely unlikely?
A. Because there's no mass nodule or other evidence for a primary tumor there apart from the most subtle of x-ray findings.
Q. And how many small cell lung carcinomas present with there being a discrete nodule in the lung?
A. The vast majority, 95 percent plus.
Q. In the small cell carcinomas of the lung that present with a discrete nodule is the discrete nodule identifiable on CT scan?
A. Is there in this case?
Q. No. This 95 plus that present with a discrete nodule in the lung are you referring to a discrete nodule identified by radiograph?

00101

A. By CT scan.
Q. And in your experience have you ever diagnosed a person to have small cell carcinoma of the lung where there was invasion of the mediastinum and no discrete nodule in the lung?
A. Yes.
Q. How many times?
A. Once that I can recall.
Q. And was that individual a smoker?
A. Yes.
Q. By the way, do you smoke, Doctor?
A. No.
Q. Have you ever?
A. No.
Q. Let me ask you this question and then we need to take a break because I need to use the rest room. Why do you believe that Ms. Henley's treating physicians have diagnosed her condition to be a small cell carcinoma of the lung and not a primary small cell thymic carcinoma?
A. Did you want to say something?
MR. BARRON: I was going to object to the question as lacking foundation but I've made the record, then you can go ahead and answer if you think you can.

00102

THE WITNESS: I don't know what in their mind led them to -- in this particular case led them to think that. It may be that they didn't -- that they are not even aware of this other entity.
It may be that they make this assumption knowing that the treatment is the same; and, therefore, it is simply not a point of great pivotal clinical importance. And since the vast majority of small cell carcinomas are found to be in the lung, it was an assumption but not based on anything other than a statistical likelihood.
MS. CHABER: Q. Is it your opinion, then, that Ms. Henley's treating physicians diagnosed a small cell carcinoma of the lung merely because of statistics?
MR. BARRON: Objection. His answer was in three parts. It's now becoming argumentative as phrased I believe. I think you ought to show more courtesy than that.

THE WITNESS: Please repeat the question.
(Record read)
THE WITNESS: No.
MS. CHABER: Q. Let's assume that the University of Southern California which is a medical center and a treating hospital is aware that there

00103

are rare instances of thymic carcinomas that are small cell type and primary. And let's assume further that they at that facility diagnosed her, told her that she had a small cell carcinoma of the lung.

Is it your opinion that they did not have a reasonable scientific medical basis for that diagnosis?

MR. BARRON: Hold your answer. The question is an improper hypothetical. You talk about they at, quote, LAC, LA Center of USC Medical Center facility knowing, and you are not identifying who goes there; everyone who is a medical doctor, certain pathologists or just what? And I think it's, therefore, an improper hypothetical which causes the linkage to the second part of the question to be an improper lack of foundation, an improper hypothetical question.

MS. CHABER: Q. You can answer.

A. I think that they may have jumped to the conclusion without having definitive evidence that there was an underlying lung lesion.

Q. And you would agree that replete throughout the records that you have been presented in this case has been the diagnosis of small cell

00104

carcinoma of the lung?

A. There are many entries that say that. There are also many other entries that simply say small cell carcinoma and don't go onto qualified or say specifically primary unknown.

Q. Can you show me where those references are?

A. Let me take some time but I'll be glad to do it.

MS. CHABER: You can look while we take a break.

(Short break from 2:50 p.m. to 2:58 p.m.)

AFTERNOON SESSION

MS. CHABER: Q. Before the break you were going to go through the medical records. Have you done so?

A. I've gone through the binder I believe there are important references in the other notes as well and since the Post-its have come off, it's going to take much longer to go through that, but I would draw your attention to some entries in here that I have made. The first is page 14 where --

Q. What facility?

A. This is the operative note from the LA County, USC Medical Center. This is the dictation

00105

of the operative report of Dr. Hagen where he says in the postoperative diagnosis presumably after a frozen section that this is possible small cell carcinoma.

He had done a bronchoscopy and a mediastinoscopy and a biopsy and he did not say small cell carcinoma of the lung. In fact, in his bronchoscopy report he says there are no obvious lesions seen and I believe that he had a -- one would have a serious question about this being a lung primary based on this operative note.

Q. Nonetheless, have you seen a report by Dr. Hagen subsequent to both the bronchoscopy and to the surgery that you are referring to where he writes Dr. Smith that this is a 51-year-old woman with small cell bronchogenic carcinoma?

A. I don't recall that. I'm sure it is possible. The second page I want to draw your attention to is I believe it's page, it looks like, 22 and this is a longhand note.

Q. 22, what facility?

A. L.A. County U.S. Medical Center. I'm looking for the date. I just don't see it but it was performed after the bronchoscopy and mediastinoscopy where they acknowledge that it was a

00106

frozen equal small cell carcinoma no primary identified on CT of the chest or intraop. That was written out longhand.

Q. Is that one of your previously marked --

A. Yes.

Q. -- tabbed pages?

A. Yes, it is.

Q. Okay.

A. And, finally, on the UCS Medical Center, page No. 35 it makes the diagnosis of a large anterior mediastinal mass biopsy frozen section showing small cell carcinoma again with no mention made of it being a lung primary. That is a longhand note after the procedure was done.

Q. And did you see any notes or reports after the procedure that you've just described in here where her doctors indicated that she had a diagnosis of small cell bronchogenic carcinoma?

MR. BARRON: Could I have that reread?

(Record read)

THE WITNESS: Yes.

MS. CHABER: Q. And your opinion would be that that diagnosis is incorrect, correct?

A. I believe the diagnosis of small cell carcinoma is correct. I believe that the -- that

00107

there's insufficient evidence to conclude that this is from a lung primary.

Q. Now, on the bronchoscopy what is -- what do you believe the radiologist was referring to when he said that there was a constellation of findings in the left lung?

A. I don't know. That's not a term that I understand what he's saying.

Q. And what do you understand him to mean when he says probable left interstitial disease -- of course, I made an assumption that it was a he -- when Dr. Yeh indicates that his impression on x-ray after bronchoscopy is probable left interstitial disease?

A. The date now is after the bronchoscopy.

You said based on bronchoscopy. So the bronchoscopy can induce many changes in the lung and the mediastinotomy can cause the patient to have pain and not cough.

Inflammatory changes were noted at bronchoscopy. I have demonstrated on these films that there is some change in the superior segment which is extremely subtle and nonspecific. I don't know where to go beyond making those comments.

Q. Where is the clivus?

00108

A. I believe it's in the skull.

Q. And do you believe that Ms. Henley has metastases to any other part of her body?

A. I don't believe Ms. Henley has any metastases at all.

Q. Did you look at the MRI of the brain?

A. No.

Q. Did you note in the records that they suspected a metastases to the clivus from the MRI?

A. I did read that report and I believe there were other reports that subsequently did not bear that out.

Q. Is that all the reports that you have noted that you were looking for during the break in the binder?

A. In the binder, yes.

Q. Now, there's another set of records and I believe counsel has attempted to reproduce your -- where the Post-its were and we've identified that on Exhibit 5A. Without taking the time to look through the entire set of records contained in Exhibit 5, I would ask you to at least flip to those pages and see if there is any notation of a diagnosis of something other than small cell carcinoma of the lung.

00109

MR. BARRON: That is a copy of Exhibit 5 that I'm giving to you or have given to you. You may keep that.

MS. CHABER: That's fine.

MR. BARRON: I didn't know what you had for sure in terms of Exhibit 5 from that which you don't have in Exhibit 5 so you can keep that and --

MS. CHABER: Very kind. Above and beyond.

MR. BARRON: What she wants you to do now is look through each of these.

THE WITNESS: I'm going backwards because it's physically easier to do that.

MR. BARRON: While he's doing that, did you want to mark this so I can give it back or do you really care? That's what you had him look at earlier which is our expert disclosure and he remembers seeing the page that deals with him.

MS. CHABER: Why don't we just mark that page. Let me mark as plaintiff's next in order page 4 of the expert witness disclosure where Dr. Warren has identified that he testified earlier that he had seen.

(Whereupon, Plaintiff's Exhibit No. 13 was marked for identification.)

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MR. BARRON: Let me make a copy. This is the only one I've got to use for my binder right now. Are you done?
THE WITNESS: I'm done.
MS. CHABER: Q. Have you found any other notations in the records that are contained in Exhibit 5?
A. Yes.
Q. Can you identify them, please?
A. Page 102 perhaps the most single important document is the pathology report where they simply identify this as small cell carcinoma and make no attempt to identify this as a pulmonary origin.
Q. Did they make any attempt to identify it with any origin?
A. They can't.
Q. Do you believe whatever the small cell carcinoma that Ms. Henley has is progressing?
A. From what I have seen from the x-rays she has had a good initial response to the therapy -- radiotherapy followed by the chemotherapy.
Q. What's the most recent x-ray or CT scan you have seen date wise?
A. Let's see, I have films from October

00111

1998. I believe that's the most recent.
Q. And how do you read those films?
A. She has had -- do you want me to -- I don't want to get these mixed up. Do you want me to take these down and put these up and go through them in the same fashion?
Q. Yes.
A. I think these belong in this jacket. The films I am putting up are from October the 10th, 1998 is a CT scan from Saint Joseph Medical Center and what I am demonstrating is a remarkable resolution of the previously described mass to the point that abnormalities are seen in windows 10 plus C and 11 plus C and that is virtually all that is left of that original mediastinal mass.
Q. Do you see any evidence of recurrent disease in the left upper lobe?
A. You say recurrent disease. Since there was no initial disease in the left upper lobe, I don't believe I can answer your question.
Q. Do you see any disease in the left upper lobe on that CT scan?
A. Yes, I do.
Q. And what do you see?
A. I see changes on Images 8 plus C, 9 plus

00112

C, 10 plus C, and I'll say 11 and 12 plus C that are in the left upper lobe and is a peripheral pleural-based density and a more central density abutting the aortic knob.
Q. What do you believe that is?
A. Radiation changes.
Q. Would it be unreasonable to conclude that what you've just described is evidence of cancer?
MR. BARRON: I'm sorry, could you read that back?
(Record read)

MR. BARRON: I'm just going to object to the phrase, quote, unreasonable as being imprecise and ambiguous.
THE WITNESS: It's more likely than not this does not represent cancer.
MS. CHABER: Q. And why do you say that?
A. Because of the location and the distribution of these lesions in the left upper lobe after the patient's radiation therapy.
Q. Were you provided with any reports of Dr. Horn?
A. I've been offered many reports. I don't recall Dr. Horn.
Q. Have you seen any reports of any experts

00113

other than yourself in this case?
A. No, I don't believe I have. I thought you may be referring to one of the many doctors seeing the patient in the clinical records.
Q. Have you seen any reports from any pathologists who are experts in the case?
A. No, I have not.
Q. And that would include also not from Dr. Gould?
A. That's correct.
Q. And early on in this deposition I believe you said that there was some significance to you that there was no change or effect on Ms. Henley's voice?
A. That's correct.
Q. And what do you base that on that there was no change or effect on Ms. Henley's voice?
A. My experience and my anatomy of the chest.
Q. How do you know that Ms. Henley has not had a change in her voice?
A. There was mention of it in the clinical records.
Q. Can you indicate what records you are referring to?

00114

A. We are back to the --
Q. If you know?
A. It is in here. I'll attempt to find it. I can't find it at this moment but my recollection is that it was in there.
Q. Okay.
MR. BARRON: Do you want to describe it for her from recollection of what you found in there on the voice question?
THE WITNESS: My recollection is that it was a handwritten note that said quite specifically that she had no changes in her voice. The significance of that is that small cell carcinomas that involve the mediastinum to the size of six centimeters and can choke off the main pulmonary artery almost always would have nipped the left recurrent laryngeal nerve which is right beside the level five nodes to which an occult primary lung cancer would bring. As a matter of fact, in some cases that is the presenting complaint with a normal chest x-ray and a normal CAT scan.
MS. CHABER: Q. Did you notice any

records indicating that Ms. Henley reported difficulty in singing as one of her reporting symptoms?

00115

A. I don't recall that.
Q. Do small cell carcinomas that are primary thymic carcinomas is a clinical presenting feature of then hemoptysis?
A. Not commonly.
Q. Is a clinical presenting feature a chronic productive cough?
A. No.
Q. You would agree Ms. Henley had only one sputum cytology done?
A. That's all I could find in the record.
Q. And there were notations that other sputum cytologies that she was supposed to have done were cancelled?
A. What I recall is Dr. Hagen stating in the time of his consultation that cytologies had been sent to the laboratory and somehow due to some mixup were not processed and yet I found in there both a longhand written report as well as a typed official report, if you wish, stating that the cytology was done and was benign, so I'm not sure if there were additional samples or whether Dr. Hagen was just misinformed.
Q. And you would agree that a cough productive of brownish sputum is not a typical

00116

presenting symptom of a primary small cell thymic carcinoma, would you not?
MR. BARRON: Could you just rephrase it? It wasn't clear to me whether you were saying not typical or --
MS. CHABER: Not typical.
MR. BARRON: Okay. You said the atypical part first. I wasn't sure if you were saying a typical or atypical as one word.
MS. CHABER: Q. You would agree that presentation with productive brownish sputum is not typical of the presentation of a primary thymic carcinoma of the small cell variety?
A. I agree -- well, there are not many cases reported, but I would agree that would be unlikely. It is also unlikely that small cell carcinoma of the lung would present with brown sputum.
Q. Tell me what are the clinical symptoms that small cell carcinoma of the lung typically presents with.
A. There are many symptoms. They would include a cough, wheezing, shortness of breath, hoarseness, weight loss, malaise. Often distant metastatic spread can be the first presentation of a small carcinoma of the lung.

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Q. How does that present as a symptom?
A. It may present with bone pain. It may present as a neurologic deficit. It may present as a mass in the liver. It may present with palpable supraclavicular adenopathy associated with some of the other symptoms. It can present as a peritoneal aplastic syndrome, including ectopic production of

ACTH and other hormone like substances.
Q. With respect to the symptoms that we've just been talking about of typical presentation of a small cell lung carcinoma, when you said cough, what type of cough?
A. An unremitting cough usually nonproductive and associated with a wheeze.
Q. And if an individual had a wheeze, might you hear rales on physical examination?
A. Yes, you may.
Q. And shortness of breath as a presenting symptom -- let me just ask you before I go through each of these, are any of the symptoms that you've just indicated, cough, wheezing, shortness of breath, hoarseness, weight loss, malaise typical presentation symptoms of small cell primary thymic cancer?
A. I think that there simply have been too

00118

few cases to be able to say one is more typical than the other. Inasmuch as it's an aggressive tumor, I would expect that it, too, would present with weight loss and malaise maybe with the symptoms of the tumor abutting surrounding structures, including the bronchus and therefore presenting with cough as I am hypothesizing in this case. If it is an anterior mediastinal mass, it may be quite asymptomatic with respect to the chest for a long time.
Q. With respect to Ms. Henley she presented with an approximate 17-pound weight loss?
A. Yes.
Q. And she presented with a shortness of breath; she reported shortness of breath?
A. She reported some shortness of breath and I'd like to clarify you said 17-pound weight loss and that certainly was in the records. It was unclear to me in reading the records carefully that that number was mentioned and was quoted and yet there were other times when simply comments were made like her clothes are fitting loosely.
So I think that that may have evolved over the course of time. I have no particular reason to think that she did not lose weight. It sounds like a very clear number that was well

00119

documented but it may not be quite so clear.
Q. Nonetheless, it's clear that she had at least what she considered a significant weight loss without having attempted to lose that weight?
A. That's true. Her appetite -- many entries there that her appetite was decreased and that she had this weight loss. There are some mentioned in the record that her -- she typically had one meal a day so her eating habits were irregular and I suspect that -- well, anyway.
Q. Had she reported weakness?
A. Yes.
Q. And she reported decrease in appetite?
A. That's correct.
Q. And she reported lack of energy?
A. Yes.
Q. And that would be what you would call malaise? You used the word malaise.

A. It means the patient doesn't feel well.
Q. And she certainly reported that she didn't feel well, correct?
A. That's correct.
Q. What do you believe the prognosis is with respect to Ms. Henley?
A. To be honest, I really don't know. There

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are references that you have in front of you that when a thymoma was excised and found by surprise to be small cell carcinoma, that a patient survived beyond five years which is very remarkable for a lung primary small cell carcinoma. The small cell carcinoma of the thymus may. Generally all cases do better than small cell carcinoma of the lung.
Q. Would you agree that is in the instance of when there is surgical excision?
A. To the best of my knowledge, that is the only five-year survivor of a small cell neuroendocrine carcinoma of the thymus.
Q. And that individual had the tumor excised?
A. That's my understanding.
Q. And the presentations at least that are reported in the reported articles of primary small cell thymic carcinoma do not report the symptomatology that you've just listed typical of small cell lung carcinoma?
A. I believe that the Rosai chapter in the textbook does make reference but I would like to see that again. It's got the heavy clip on it. May I?
Q. Yes.
A. This reference is a chapter in a

00121

pathology annual. It deals primarily with carcinoid tumors of the thymus.
Q. You are referring to Exhibit 6?
A. I'm referring to Exhibit 6. It does not make reference to the clinical presentation of those patients thought to have small cell carcinoma of the thymus. In fact, the diagnosis at this time was made at autopsy, but he makes no reference of the clinical course of that patient, including the natural history or how long that patient had symptoms or what those symptoms were.
It would be my assumption that they would be -- that the malaise and the lack of energy, etc., the weight loss would be much the same as with small cell carcinoma of the lung and haven't heard any distinction based on the clinical presentation between the two.
MR. BARRON: It's half past 3:00 now.
MS. CHABER: I'm trying to just wrap this up because I know the doctor has to leave.
Q. So you have no opinion, then, as to what the prognosis is for Ms. Henley; is that correct?
A. Well, let me say that it's my understanding that the average survival for small cell carcinoma of the lung is on the order of a year

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and a half. And given her x-ray in October and given the plain x-ray and the CAT scan in October and given the absence of convincing distant

metastases, she seems to be doing better than what a small cell neuroendocrine carcinoma of the lung would be doing. And I can't predict beyond that but she seems to be doing extremely well for a patient if it were to turn out that she has a lung primary.

Q. There are survival rates of small cell lung carcinoma that are two and three years?

A. Of the lung?

Q. Yes.

A. Yes.

Q. And generally those people are the people who have had a good response to radiation and/or chemotherapy?

A. Generally speaking, yes.

Q. And would you say that Ms. Henley has had a good response to radiation and chemotherapy?

A. She's had an excellent response.

MR. BARRON: I think we located that citation.

THE WITNESS: Would you like me to read that into the record?

MS. CHABER: Yes.

00123

THE WITNESS: On page 190 of Exhibit 5 and at the top of the page it says, "Specifically the patient has not noted any changes with her voice and her swallowing has been normal."

MS. CHABER: Q. What's the date of that?

A. 2-17-98.

Q. But you don't recall seeing earlier references when she first presented that she did have some mild difficulty swallowing?

A. Yes, I do -- I found that in the record but they were vague and difficulty swallowing she had associated nausea and, in fact, there's a notation somewhere that she vomited.

Q. Doctor, when you indicated you were deposed 10 to 12 times, can you tell me the nature of those depositions?

A. Most of them were medical malpractice cases.

Q. And was there any instance in those medical malpractice cases where you were testifying on behalf of the injured person?

A. Yes, twice at least.

Q. Were those people your patients at that time or were you designated as an expert to review the information?

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A. No, in both of those cases I never met the patient. At least I was never a treating physician.

Q. Did you testify in court in any cases?

A. I have testified in court on one occasion on behalf of a patient whom I operated on and was going through a divorce and somehow they wanted my opinion as to how her hiatal hernia repair impacted on her state of mind in a divorce proceeding. That's the only time -- oh, there is a second case. In the second case I was defending a doctor.

Q. Where was the first case?

A. Chicago. Both cases were in Chicago.

Q. Were they both in superior court?

A. I honestly don't remember. I don't believe divorce court was downtown. They are both downtown.
Q. One was a divorce court; the other was an action for medical malpractice for you defending a doctor?
A. Yes.
Q. And what year was that?
A. Which, the first or the second?
Q. The medical malpractice case.
A. It was either last year or the year

00125

before, that is, 1997 or 1996.
Q. And just give me two seconds to quickly review my notes and try and get this concluded. And subsequently we will go on and then after the doctor's left and identify the x-rays and radiographs that we have for the record.
MR. BARRON: Correct, you can help me as to whether you and Bill and Lucy have developed any standard agreement stipulations concerning reading and signing the transcript.
MS. CHABER: No, we have developed nothing. Let me also give the doctor another 500 dollar check and I would ask you, Doctor, to bill me for the remainder. You can obviously provide it through the counsel and when I receive that --
THE WITNESS: The remainder for our time in deposition today?
MS. CHABER: Yes.
THE WITNESS: Fine.
MS. CHABER: Preparation time is their responsibility and you can add that.
Q. Do you anticipate doing any additional work in preparation for testifying in this case?
MR. BARRON: Let him answer that on his own and I need to speak to that for you so you don't

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have any misunderstandings of my position in that regard.
THE WITNESS: I do intend to continue to pursue literature including a reference I have not been able to find yet pursuant to my interest in this very unusual case, yes.
MS. CHABER: To the extent, Doctor, that you find additional articles -- obviously the one that you are still looking for is identified -- I would ask you to identify that for counsel. And, Counsel, I would ask for further identification of that.
If you intend to have him continuing to do that, I'm not suggesting that I necessarily need a deposition subsequent to that, but I would like to know what additional work the doctor does, particularly with respect to looking for and finding additional references to support his opinions. You wanted to say something?
MR. BARRON: I was just going to give you an example. You know that we were interested in securing a copy if the originals weren't available for viewing of the films taken at Alta Bates and I spoke to your office about that and I'm sure you are aware of the circumstances that led to us --

00127
MS. CHABER: The first we heard about it was on Friday and we were unable to comply with your request to get them, but yes.
MR. BARRON: Q. So they were taken close in time to the ones that are available that may or may not be very significant.
MS. CHABER: Obviously the issue is ongoing. And to the extent that there's additional medical records, I would just reserve that if the doctor in any way changes or modifies his opinions based on any of these additional materials, I would reserve my right to depose him on those limited issues and recognizing the time and that you have a plane to catch, Doctor, I will conclude the deposition at this time subject to those reservations. Let's go off the record for a second.
(Off the record)
(Dr. Warren exited proceedings at 3:42 p.m.)
MR. BARRON: Counsel has asked me to try to identify what diagnostic films we had here to have available for Dr. Warren and identify them by date and general category and I will do my best to do that.
We have films that appear to be all dated January 3rd, 1998 from Saint Joseph's and I'm not
00128
qualified as a radiologist as counsel will agree, I'm sure, but it looks like we have two so-called plain films and I think if I counted correctly, eight CT sheets with multiple exposures.
MS. CHABER: From the same location?
MR. BARRON: Yes. I have another folder here. I haven't taken the time to put each one up on the view box as I did with the others. The label on the outside of the folder says LAC-USC with dates of January 30th, 1998; February 5th, 1998; February 6th, 1998.
Do you want me to take the time and try to look at each one?
MS. CHABER: No. That's fine.
MR. BARRON: Then I have another envelope here that says from Saint Joseph's and there are again quite a few sheets here and the envelope says they are March 5, it looks like, '98 and August 5, 1998; and, again, do you accept that as enough?
MS. CHABER: That's sufficient, Counsel.
MR. BARRON: Okay. And then we have an envelope that again says Saint Joseph's MC, for medical center, with two dates October 5, 1998; and October 10, 1998; and quite a few sheets. And generally as I remember them, most of the sheets
00129
related to cuts of parts to which the doctor did not specifically refer other anatomical areas; in other words, I guess they were looking for sites of metastasis and I think it was the October 10 sheets that he spent some time with; and, again, I haven't put each of these sheets up on the screen. Is that enough?
MS. CHABER: That's sufficient.
MR. BARRON: Okay. Anything else we need to accomplish?

MS. CHABER: The only other thing I would do is to just mark the notice of deposition as the last document.

(Whereupon, Plaintiff's Exhibit No. 14 was marked for identification.)

MR. BARRON: Okay.

MS. CHABER: I think that does it.

(Deposition concluded at 4:00 p.m.)

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SIGNATURE OF WITNESS